Wade-Taxter, Megan (ISDH)

From: Becker, Angela

Sent: Wednesday, September 19, 2018 2:19 PM

To: Wade-Taxter, Megan (ISDH) **Subject:** FW: ISDH records request

Attachments: 2017 Clinic for Women.pdf; 2017 PPINKY Bloomington.pdf; 2017 PPINKY Indy.pdf; 2017

PPINKY Lafayette.pdf; 2017 PPINKY Merrillville.pdf; 2017 Women's Med Group.pdf

Categories: Saved to Folder

From: Becker, Angela

Sent: Thursday, June 29, 2017 10:40 AM

To: Humbarger, Cathie < Cathie. Humbarger@Ichooselife.org>

Cc: Snyder, Randall <RSnyder1@isdh.IN.gov>; Becker, Angela <ABecker2@isdh.IN.gov>

Subject: ISDH records request

Good morning Ms. Humbarger.

Pursuant to your request, the Indiana State Department of Health is providing copies of all applications for abortion facility licenses submitted to this Agency between May 9, 2017 and June 26, 2017.

Kind Regards,

ANGELA L. BECKER

Litigation Liaison & Public Records Coordinator
Office of Legal Affairs
Indiana State Department of Health
317.232.3119 office
317.234.6278 fax
abecker2@isdh.in.gov
www.StateHealth.in.gov









Confidentiality Statement:

This message and any attachments may be confidential. If you are not the intended recipient, please 1) notify me immediately; 2) do not forward the message or attachment; 3) do not print the message or attachment; and 4) erase the message and attachment from your system.

From: Cathie Humbarger [mailto:cathie.humbarger@ichooselife.org]

Sent: Sunday, June 25, 2017 4:21 PM



June 26, 2017

Randall Snyder Division Director, Acute Care Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204

Dear Mr. Snyder,

I am requesting copies of all applications for abortion facility licenses submitted to the Indiana State Department of Health between May 9, 2017 and June 26, 2017. Please send to the address below or e-mail to cathie.humbarger@ichooselife.org.

Please let me know of any cost related to this request and I will remit payment immediately.

Mail to:

Cathie Humbarger, VP Indiana Right to Life 2126 Inwood Drive Fort Wayne, IN 46815

Sincerely,

Vice President of Policy Enforcement

Indiana Right to Life

Cathie Dumbarger





	Division of	Acute Care Use Only		
Date Received (mm/dd/yyyy)	Date Approved	(mm/dd/yyyy)	Date Rejected (n	nm/dd/yyyy)
Please Type or Print Legibly.				
		TYPE OF APPLICATION	1	
Application (Check appropriate item.,				,
□ New Facility Renewal S	Change of Ownership (Aubmit a dated and signed co	Anticipated date of Sale/Puppy of the bill of sale, lease	urchase/Lease (mm/dd/y or other document of tran	yyy)) nsfer.
	SECTION II - IDI	ENTIFYING INFORMAT	ION	
A. Abortion Clinic Location				
Name of Abortion Clinic	Jomen			
Street Address (number and street)	104h St.	23		P.O. Box
City Indols IN		County) n	ZIP Code +4 * (4222
Telephone Number Fax Number			8	
(317) (317)		ddress: Cfw @ C	linia Husami	n net
(317) (317) 955.2641 955.2689	Abortion Clinic e-mail a	ddress:	michwone	71.110
133.2041 735.200)	1			,
	Internet Web Address:	www.clinic	4 women. M	<i>t</i>
			,	
B. Mailing Address (if different from	abortion clinic location)			
Street Address (number and street)				P.O. Box
City		County		ZIP Code +4
C. Licensee/Ownership Informatio	n			
Licensee: The applicant entity as register		te		
Comment of the second of the s	2 d'ana			
Street Address (number and street)	naiana			P.O. Box
3607 West 16+1	Street			
City	01100	State		ZIP Code+4
Indianapolis		India	na	44222
Telephone Number Fax Nu	ımber	EIN Number	Fis	cal Year End Date (mm/dd)
317 955 2641 317	955 2687	35139171	10 /0	2.31

Code items 1 and 2 as follows: 1. Provided directly by employed	e(s), 2. Provided by a contract service, 3. Both 1 and 2.	
1. Ancillary Services: Laboratory: CLIA C	ertificate Number 15D0894576	Radiology Counseling
Family Planning	Pharmacy Other (List):	
2. Surgical Services: Gynecology	Other (List): Abortion Sec	
For item 3, indicate the total number of individuals (employees p	lus contractors) working in this clinic. This includes hou	rly, part-time, and full-time persons.
3. Staffing: Physicians: Registered Nurses Licensed Social Workers:	: Licensed Practical Nurses: Other (List title and number):	1- Sure assistants 1- Lab Tech 1- Mad. assistants 0- Pt. Educations 0- Specimen Techs
E. Number of Procedure Rooms Utilizing:		
Local analgesia/anesthetic	Moderate/Conscious Sedation	
F. Type of Entity:	6 - Y	
<u>For Profit</u>	Non-Profit	Government
	Non-Profit Church Related	Government State
For Profit		☐ State ☐ County
For Profit Individual	☐ Church Related ☐ Individual ☐ Partnership	☐ State ☐ County ☐ City
For Profit Individual Partnership	Church Related Individual Partnership Corporation	☐ State ☐ County ☐ City ☐ City/County
For Profit Individual Partnership Corporation	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company	☐ State ☐ County ☐ City ☐ City/County ☐ Hospital District
For Profit Individual Partnership Corporation Limited Liability Company	Church Related Individual Partnership Corporation	State County City City/County Hospital District Federal
For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company	☐ State ☐ County ☐ City ☐ City/County ☐ Hospital District
For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	 ☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other (specify) 	State County City City/County Hospital District Federal
For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	 ☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other (specify) 	State County City City/County Hospital District Federal
For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	 ☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other (specify) 	State County City City/County Hospital District Federal
For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	 ☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other (specify) 	State County City City/County Hospital District Federal
For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	 ☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other (specify) 	State County City City/County Hospital District Federal
For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	 ☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other (specify) 	State County City City/County Hospital District Federal
For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	 ☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other (specify) 	State County City City/County Hospital District Federal

G. Officers (if the business entity is inco	orporated)	0	
Position	Name	Address	/City/State/ZIP
President/Chairperson/CEO	La Donna Prince	Toos Norm	44278
Vice-President/Vice-Chairperson/COO	Sally Boone	Cornel, In	on Way 1 4 6 098
Treasurer/CFO	Mel. SSa Baker	July 5 . 40	y 46303
Secretary	Linda Williams	Indps, I	N44228
H. Ownership and/or Change in Ownersh	ip:		
List names and addresses of individuals or on the applicant entity. Indirect ownership intentity higher in a pyramid than the applicant	organizations having direct or indirect or erest is an entity that has an ownership	p interest in the applicant er	itity. Ownership in any
Name	Business Addres	s/City/State/ZIP	EIN Number
La Donna Prince	3607 10 1691 S	+ Indols IN4Wa	351391710
Tennis Mickle	3x07W. 164 St.	Indps 10 44220	35/39/7/(
		11 2 8 012	
	CERTIFICATION OF APPLICAT	ION	
The undersigned hereby makes application this application, represents and shows that with the Abortion Clinic statues, IC 16-21-2-maintain this clinic in accordance with those	the owner(s) and operator(s) are of rep 2.5 and IC 16-34, and the rules promu	outable and reasonable cha	racter, are able to comply
I certify that the operational policies of the c	linic will not provide for discrimination b	pased upon race, color, cree	ed, or national origin.
I swear and affirm under the penalty of perjudent complete and that I will comply with all regu	ury that all statements made in this applications, laws, and rules governing the l	olication and any attachmen icensing of clinics in Indiana	ts thereto are correct and a.
Signature of the Medical Director:	DO 140		
Printed Name and Title:	J. Raymond Robin.	son	
Date of Signature (mm/dd/yyyy):	16.0%.2017)		
Signature of the Clinic Administrator:	Landonia plin	w	
Printed Name and Title:	aDonnatrince,	Director	
Date of Signature (mm/dd/yyyy):	06/04/2011		
See the following page for	r instructions regarding	licensure fees	and submission
of this application.			

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	\$500.00
	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

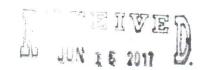
Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

- 1. A completed Application for License to Operate an Abortion Clinic (this form).
- 2. Any supporting attachments.
- 3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's admitting privileges; or
 - (B) A copy of:
 - (1) his/her written agreement with another physician with admitting privileges; and
 - (2) a copy (in writing) of that physician's admitting privileges.
- 4. Payment made payable to "Indiana State Department of Health."

Mail to:





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		<u>Divisior</u>	of Acute Care Use Only		
Date Received (n	nm/dd/yyyy)	Date Appro	ved (mm/dd/yyyy)	Date Rejected (n	nm/dd/yyyy)
Please Type or Pr	int Legibly.				
		SECTION	I - TYPE OF APPLICATION		
Application (Chec.	k appropriate item.,)			
☐ New Facility [Renewal St	Change of Ownershi	ip (Anticipated date of Sale/Purcha ed copy of the bill of sale, lease or oth	se/Lease (mm/dd/yy ner document of trans	yy))sfer.
		SECTION II -	IDENTIFYING INFORMATION		
A. Abortion Clinic	And the last terminates and				
Name of Abortion Clin			-		
Planned Pai	renthood	of India	na and Kentuc	KV-Blood	minaton
1101 / Aut	er and street)				P.O. Box
421 5. Colle	ege AVE				
Bloomingt	DN		County		ZIP Code +4 47403
Telephone Number	Fax Number				
(812) 336- 0219	(912) 336- 2401	Abortion Clinic e-mai	il address: Lauva · Mille	r@ppink	c. org
-			s: WWW. ppink.org		
B. Mailing Address	(if different from a	bortion clinic location	7)		
Street Address (numbe	r and street)				P.O. Box
200 S. Mer	Idian St.	, Julte 4	100		
			County		ZIP Code +4
Indianap	0 1. 0		Marion		46225
C. Licensee/Owner	ship Information				14220
Licensee: The applican		with the secretary of st	ate		,
Street Address (number	arenthou	a of Ir	ndiana and Kei	ntucky,	Inc.
200 S. ME	eridian St	t. Suite	400		P.O. Box
200 S. ME Indianapoli	ć	•	State //		ZIP Code+4
Telephone Number	Fax Numb	er	EIN Number		16225
317, 437-43	343 3171	037-4344	35-0874276		ear End Date (mm/dd)
	101.//		00 0014216		06/30

D. Services provided	under this license:		
Code items 1 and 2 as follows	: 1. Provided directly by emplo	oyee(s), 2. Provided by a contract service, 3. Both 1 an	d 2.
1. Ancillary Services:	Laboratory: CLIA	Certificate Number 1500360690	Radiology Counseling
	Family Planning	O Pharmacy O Other (List):	
2. Surgical Services:	Gynecology C	Other (List):	
For item 3, indicate the total n	umber of individuals (employees	plus contractors) working in this clinic. This includes he	purks partiting and fell singer
3. Staffing: Physicians:	- I-ADN		say, par-time, and fun-time persons.
L	icensed Social Workers:	Chief (Elst title and number):	tealth Center Assistants - Nter Manager - 1
E. Number of Procedi	ure Rooms Utilizing:		Marrager 1
Local analgesia/ane	esthetic 2	Moderate/Conscious Sedation	
F. Type of Entity:			
For Profit		Non-Profit	Government
☐ Individual		Church Related	
Partnership		Individual	☐ State
Corporation		Partnership	☐ City
Limited Liability Company		Corporation	☐ City/County
Sole Proprietorship		Limited Liability Company	☐ Hospital District
Other (specify)		Olher (specify)	Federal
			Other (specify)
			Girlei (specify)
			I I

MI	n Cireen Chael Carter Ethan Ringhan	200 S. Me Suite 400 Indianap	ridian St. O
MI	chael Carter	Indianap	oriaran st.
Na		Indianap	
-	ethan Ringhan		0115, IN 46205
-		7	
UP	ristie Moore		
ganizati	ons having direct or indirect own	ership or controlling int	erest of five percent (5%)
onstitule	Tosa and	uonai sneet it necessat	<i>y.</i>)
	Dusiness Address/Ci	ity/State/ZIP	EIN Number
-			
4.			
owner(s and IC es.	e to operate an Abortion Clinic (6) and operator(s) are of reputable 16-34, and the rules promulgated	Clinic) in the State of In e and reasonable char: I there under, 410 IAC	diana, and in support of acter, are able to comply 26 and will operate and
will not	provide for discrimination based	UDON race color cree	d of national arists
1	11/		
	Stutsman M.	dinal Dive	chic
113	12017	area pire	CIOV
-	2		
era	Miller Cont	ec Maria	3
3/17	- Cufe	1 1-100	Ser
	CERT a licens owner(s and IC es. will not hat all s ins laws	CERTIFICATION OF APPLICATION a license to operate an Abortion Clinic (cowner(s) and operator(s) are of reputable and IC 16-34, and the rules promulgated es. will not provide for discrimination based that all statements made in this applications laws, and rules governing the license laws, and rules governing the laws and rules governi	ganizations having direct or indirect ownership or controlling interest is an entity that has an ownership interest in the applicant econstitutes indirect ownership. (Use additional sheet if necessary Business Address/City/State/ZIP CERTIFICATION OF APPLICATION a license to operate an Abortion Clinic (Clinic) in the State of Incoverse and IC 16-34, and the rules promulgated there under, 410 IAC es. will not provide for discrimination based upon race, color, creed that all statements made in this application and any attachments have, and rules governing the licensing of clinics in Indiana. Thutsman Mudical Direction and any attachments have, and rules governing the licensing of clinics in Indiana.

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
V	Zero to 799	\$500.00
	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

- 1. A completed Application for License to Operate an Abortion Clinic (this form).
- 2. Any supporting attachments.
- 3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's admitting privileges; or
 - (B) A copy of:
 - (1) his/her written agreement with another physician with admitting privileges; and
 - (2) a copy (in writing) of that physician's admitting privileges.
- 4. Payment made payable to "Indiana State Department of Health."

Mail to:





		Division of	F Acuto Comp Illes	0.1	
		DIVISION OF	f Acute Care Use	Only	
Date Received (n	mm/dd/yyyy)	Date Approved	d (mm/dd/yyyy)	Date Rejec	ted (mm/dd/yyyy)
Please Type or Pr	rint Legibly.				
		SECTION I -	TYPE OF APPLICA	TION	
Application (Chec	k appropriate item.)		THE OF AFFEIGA	TION	
☐ New Facility ☐	Renewal Su	Change of Ownership (Abbail a dated and signed co	Anticipated date of Sa. opy of the bill of sale, le	le/Purchase/Lease (mn ase or other document	n/dd/yyyy)) of transfer.
		SECTION II - IDI	ENTIFYING INFORM	MATION	
A. Abortion Clinic			THE IN OIL	IATION	
Name of Abortion Clin					
Planned Pai	renthood	of Indian	a and Ke	ntucky - 1	odianapolic
0390 (3201	er and street) GETOWN R	of Indiana	AC NING RE	MUCEY	P.O. Box
Indianap			County	on	ZIP Code +4 40268
Telephone Number	Fax Number				14343
(317)	(317)				
872-	872-	Abortion Clinic e-mail ad	dress: 180016	v. hederir	naton Oppink org
3115			2		Jan Spring
00	3188	Internet Web Address: V	MAMAL DOIN	DICA	
		The red Address.	ANALY POINTE	000	
				,	
B. Mailing Address	(if different from a	bortion clinic location)			
Street Address (numbe					P.O. Box
200 S. Mer	Idian St.	Suite 400	0		
		00110	County		ZIP Code +4
Indianap	nolis		Marie	N/A	
C. Licensee/Owner			1101110	7	46225
icensee: The applican	it entity as registered	with the secretary of state			
Planua P Street Address (number	arenthoo	d of Ino	liana and	Kentuck	y, Inc.
	eridian St	_		/	P.O. Box
Indianapoli	Ś		State		ZIP Code+4 4ia 77.5
elephone Number	Fax Numb		N Number	I	Fiscal Year End Date (mm/dd)
317, 437-4	349 3171	037-4344 3	5-087112-	710	21 /20

D. Services provided under this license:		
Code items 1 and 2 as follows: 1. Provided directly by em	ployee(s), 2. Provided by a contract service, 3. Both 1 a	nd 2.
1. Ancillary Services: Laboratory: CLL	A Certificate Number 1500360690	Radiology D Counseling
Family Planning	O Pharmacy O Other (List);	
2. Surgical Services: Gynecology	Other (List):	
For item 3, indicate the total number of individuals (employe		rough next size at C.V.
3. Staffing: Physicians: 5 Registered Nurs	ses: 3 Licensed Practical Nurses: 0	iourly, part-time, and full-time persons.
Licensed Social Workers:	Chief (Els) the una namber). I	Health Center Assistants - enter Manager - 1
E. Number of Procedure Rooms Utilizing:		The marrager 1
Local analgesia/anesthetic 2	Moderate/Conscious Sedation	2
F. Type of Entity:		
For Profit	Non-Profit	Course
☐ Individual	☐ Church Related	Government
☐ Partnership	☐ Individual	State
Corporation	Partnership	County
Limited Liability Company	Corporation	☐ City ☐ City/County
Sole Proprietorship	Limited Liability Company	☐ Hospital District
Olher (specify)		1
	Olner (specify)	Federal
	Olher (specify)	☐ Federal ☐ Other (specify)
		Other (specify)

G. Officers (if the business entity is inc Position	Nome	Address/Clty/State/ZIP
President/Chairperson/CEO	Kim Cireen	200 S. Meridian St. Suite 400
Vice-President/Vice-Chairperson/COO	Michael Carter	Indianapolis, IN 4682
Treasurer/CFO	Nathan Ringhan	7
Secretary	Christie Moore	
l, Ownership and/or Change in Ownershi	0:	
ist names and addresses of individuals or on the applicant entity. Indirect ownership Inte ntity higher in a pyramid Ilhan the applicant of	ganizations having direct or indirect own rest is an entity that has an ownership in constitutes indirect ownership. (Uso addi	ership or cantrolling interest of live percent (5%) lerest in the applicant entity. Ownership in any flonal sheet if necessary.)
Name .	Business Address/C	

a undersigned hereby makes application for	CERTIFICATION OF APPLICATION	Clinic) in the State of Indiana, and in support of
In the Abortion Clinto statues, IC 18-21-2-2,5 intain this clinto in accordance with those runtify that the operational policies of the clintonal policies of the clintonal policies.	and IC 16-34, and the rules promulgateries. will not provide for discrimination based	d there under, 410 IAC 26 and will operate and upon race, color, creed, or national origin.
mature of the Medical Director:	JAMA M	
nied Name and Title:	IT Stutsman, MI	dical Director
o of Signaluro (min/dd/yyyy):	113/2017	" COLOR
nature of the Clinic ministrator:	mile Hedelinger	
ated Marne and Title:	Jennifer Hedelington	1) 0
	TO THE TOTAL OF THE PARTY OF TH	Heath Center Manager
e of Signature (mm/dd/yyyy):	06/13/2017	The state of the s

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check	Total First Trimester	46.44
One	Procedures in the Clinic	Fee
	Zero to 799	\$500.00
X	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	
diana II	11.10	\$3,000.00

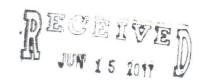
Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

- 1. A completed Application for License to Operate an Abortion Clinic (this form).
- 2. Any supporting attachments.
- 3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's admitting privileges; or
 - (B) A copy of:
 - (1) his/her written agreement with another physician with admitting privileges; and
 - (2) a copy (in writing) of that physician's admitting privileges.
- 4. Payment made payable to "Indiana State Department of Health."

Mail to:





		Division 64			
		DIVISION Of A	cute Care Use	Only	
Date Received (n	nm/dd/yyyy)	Date Approved (mm/dd/yyyy)	Date Reje	cted (mm/dd/yyyy)
Please Type or Pr	int Legibly.				-
A - E - (C)		SECTION 1 - TY	PE OF APPLICA	TION	
Application (Chec	k appropriate item.)				
☐ New Facility ☐	Renewal Su	Change of Ownership (Antibodies and signed copy	ficipated date of Sa y of the bill of sale, le	nle/Purchase/Lease (m ease or other document	t of transfer.
		SECTION II - IDEN	TIFYING INFORM	MATION	
A. Abortion Clinic	Location		THE IN OR	and told	
Name of Abortion Clin					
Planned Pai	renthood	of Indiana	and Ve	ntuply-1	ofallatte
Street Address (numb	er and street)	· Indiana	LUTIO AL	MUCKY	Maytil
164 MEZZ	anine Di	rive			F.O. 60x
Lafayet			County	canoe	ZIP Code +4
Telephone Number	Fax Number		1. PPC	curroc	47905
(765)	(765				
446-		Abortion Clinic e-mail addre	ess: 1ackie	. Key anni	inv. ora
	446-)	TOPP	
8078	8160	1. /	14 /14/ 20ia/	DICA	
		Internet Web Address: W	MM. Phill	·OVA	
	19		-	. /	
B. Mailing Address	(if different from a	bortion clinic location)			
Street Address (number	er and street)	bortion clinic location)			
200 S. Mer	idian St.	Suite 400			P.O. Box
l /·) .	•	County		ZIP Code +4
Indianas	10115		Mari	ÓN	46225
C. Licensee/Owner	ship Information				16223
Licensee: The applicar	nt entity as registered	with the secretary of state			
Planned 1.	arenthou	ed of Indi	ana ana	Kentuck	ey, Inc.
	eridian S-	t. Suite 40			P.O. Box
maranagon	Ś	1	State //		ZIP Code+4 4 in 77.5
Telephone Number	Fax Numb		Number		Fiscal Year End Date (mm/dd)
317, 437-4	549 (317)1	037-4344 35	-08742	710	06/30
			01-12	14	UUIJU

D. Services provided under this license:		1
Code items 1 and 2 as follows: 1. Provided directly by employ	ee(s), 2. Provided by a contract service, 3. Both 1 and 2	2.
	Certificate Number 1500360690 O Pharmacy O Other (List):	Radiology D Counseling
2. Surgical Services: 1 Gynecology 0	Other (List):	
For item 3, indicate the total number of individuals (employees p	olus contractors) working in this clinic. This includes how	rly, part-time, and full-time persons.
3. Staffing: Physicians: H Registered Nurses	Licensed Practical Nurses:	
Licensed Social Workers:		ealth Center Assistants - Her Manager - 1
E. Number of Procedure Rooms Utilizing:		J
Local analgesia/anesthetic F. Type of Entity:	Moderate/Conscious Sedation	
For Profit	Non-Profit	Government
	Vinda de la constantina della	Covernment
☐ Individual	Church Related	
☐ Individual ☐ Partnership		State
	☐ Church Related	
Partnership	☐ Church Related	☐ State ☐ County
Partnership Corporation Limited Liability Company Sole Proprietorship	☐ Church Related ☐ Individual ☐ Partnership	☐ State ☐ County ☐ City
Partnership Corporation Limited Liability Company	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation	State County City City/County Hospital District Federal
Partnership Corporation Limited Liability Company Sole Proprietorship	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company	☐ State ☐ County ☐ City ☐ City/County ☐ Hospital District
Partnership Corporation Limited Liability Company Sole Proprietorship	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other (specify)	☐ State ☐ County ☐ City ☐ City/County ☐ Hospital District ☐ Federal
Partnership Corporation Limited Liability Company Sole Proprietorship	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other (specify)	☐ State ☐ County ☐ City ☐ City/County ☐ Hospital District ☐ Federal
Partnership Corporation Limited Liability Company Sole Proprietorship	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other (specify)	State County City City/County Hospital District Federal
Partnership Corporation Limited Liability Company Sole Proprietorship	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other (specify)	State County City City/County Hospital District Federal
Partnership Corporation Limited Liability Company Sole Proprietorship	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other (specify)	☐ State ☐ County ☐ City ☐ City/County ☐ Hospital District ☐ Federal
Partnership Corporation Limited Liability Company Sole Proprietorship	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other (specify)	State County City Hospital District Federal

Position	Name Name	Address	/City/Stale/ZIP
President/Chairperson/CEO	Kim Cireen	200 S. Mer Swife 400	
Vice-President/Vice-Chairperson/COO	Michael Carter	Indianapo	115, IN 46225
Treasurer/CFO	Nathan Ringham		
Secretary	Christie Moore		/
Ownership and/or Change in Ownershi Ist names and addresses of Individuals or on the applicant entity, Individual ownership into antity higher in a pyramid than the applicant.	rganizations having direct or indirect owne erest is an entity that has an ownership into	rest in the applicant er	Hily. Ownership in any
Name	Business Address/Cit	y/State/ZIP	EIN Number
			-
	· · · · · · · · · · · · · · · · · · ·		
	CERTIFICATION OF APPLICATION		
The undersigned hereby makes application in his application, represents and shows that the with the Abortion Clinic statues, IC 16-21-2-2 maintain this clinic in accordance with those	or a license to operate an Abortion Clinic (/ no owner(s) and operator(s) are of reputable. .5 and IC 16-34, and the rules promulgate:	e and reasonable char	acter, are able to comply
certify that the operational policies of the cli	nic will not provide for discrimination based	upon race, color, cree	ed, or national origin.
swear and affirm under the penalty of perjuit complete and that I will comply with all regula	y that all statements made in this applications laws, and rules governing the licens	on and any allachmen Ing of clinics in Indiana	is thereto are correct and
signature of the Medical Director:	VALLA III)	
rinted Name and Tille:	ohn Stutsman, Mu	dical Dir.	ector
Date of Signature (mm/dd/yyyy):	16/13/2017		
Signature of the Clinte Administrator:	Mirchell. 14	×	
Printed Name and Title:	Jackie M. Key, 1	fealth Ca	ntermanage
Date of Signature (mm/dd/yyyy):	6.13.17		Ü
See the following page for			

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One/	Total First Trimester Procedures in the Clinic	Fee
V	Zero to 799	\$500.00
	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

- 1. A completed Application for License to Operate an Abortion Clinic (this form).
- 2. Any supporting attachments.
- 3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's admitting privileges; or
 - (B) A copy of:
 - (1) his/her written agreement with another physician with admitting privileges; and
 - (2) a copy (in writing) of that physician's admitting privileges.
- 4. Payment made payable to "Indiana State Department of Health."

Mail to:



APPLICATION FOR LICENSE

DECEIVED

H		Division	f Acute Care Use O		
Date Received (n	nm/dd/yyyy)			Date Rejected (mm/dd/yyyy)
Please Type or Pi	rint Legibly.				
		SECTION I	TYPE OF APPLICATI	ON	
Application (Chec	k appropriate item.)				
☐ New Facility [Renewal Su	Change of Ownership (bmit a dated and signed of	Anticipated date of Sale copy of the bill of sale, least	/Purchase/Lease (mm/dd/y se or other document of trai	nsfer.
		SECTION II - ID	ENTIFYING INFORMA	TION	
A. Abortion Clinic					
Name of Abortion Clin			•		3
Street Address (numb	enthood	of Indian	a and Ken	tucky-Mer	rill ville.
8645 Conr	recticut &	Chicago		1101	P.O. Box
City CUII	ila ilut	STILLET			
Merrillyi	IIP.		County		ZIP Code +4
Telephone Number	Fax Number		Lake		46410
1219) 769- 3500	(219) 791- 0538	Internet Web Address:	WWW.ppink.		@ppink.ovg
B. Mailing Address	s (if different from a	bortion clinic location)			
Street Address (number		0 '			P.O. Box
200 S. Mer	Idian St.	Julte 40	0		
Indianap			County	n	ZIP Code +4 410 225
C. Licensee/Owner	ship Information			1	14225
Licensee: The applicar	nt entity as registered	with the secretary of state	1		
Street Address (number	er and street)	a of Inc	diana and	Kentucky,	Inc.
200 S. ME	eridian St	. Suite			P.O. Box
Indianapoli	Ś		State		ZIP Code+4 4ia 7.7.5
211 127 11	Fax Numb		IN Number	Fiscal	Year End Date (mm/dd)
317, 437-4	042 1317,1	037-4344 3	5-087427	6	01.120

D. Services provided under this license:		
Code items 1 and 2 as follows: 1. Provided directly by emp.	oyee(s), 2. Provided by a contract service, 3. Both I an	d 2.
1. Ancillary Services: Laboratory: CLIA	Certificate Number 1500360690	Radiology D Counseling
Family Planning	O Pharmacy Other (List):	
2. Surgical Services: 1 Gynecology	Other (List):	
For item 3, indicate the total number of individuals (employees		
3. Staffing: Physicians: Registered Nurse		y, part-time, and jun-time persons.
Licensed Social Workers:	Chair (Bist title and number).	tealth Center Assistants - Co
E. Number of Procedure Rooms Utilizing:	mcuity (e	nter Manager - 1
Local analgesia/anesthetic 2	Moderate/Conscious Sedation	
F. Type of Entity:		
For Profit	Non-Profit	Government
☐ Individual	Church Related	_
Partnership	☐ Individual	☐ State
Corporation	Partnership	☐ City
Limited Liability Company	Corporation	☐ City/County
Sole Proprietorship	Limited Liability Company	☐ Hospital District
Other (specify)	Olher (specify)	Federal
		Other (specify)
		Sinci (specify)
		1.
	·	1

Position	corporaled) . Name	Adden	ss/City/State/ZIP
President/Chairperson/CEO	Kim Green	200 S. Met Suite 400	ridian st.
Vice-President/Vice-Chairperson/COO	Michael Carter	Indianapa	115, IN 46225
Treasurer/CFO	Nathan Ringhan	7	
Secretary	Christie Moore		
Ownership and/or Change in Ownershi I names and addresses of Individuals or o he applicant only. Indirect ownership Inte ity higher in a pyramid Iltan the applicant	rganizations having direct or indirect own	erest in the applicant er	rest of five percent (5%) ntity. Ownership in any
Name	Business Address/Ci	ional sneat II necessar)	/-)
		7.000.002.0	EIN Number
	CERTIFICATION OF APPLICATION		
undersigned hereby makes application for application, represents and shows that the the Abortion Clinic statues, IC 16-21-2-2, that in this clinic in accordance with those rules.	a license to operate an Abortion Clinic (Cowner(s) and operator(s) are of reputable	Sinic) in the State of Inc a and reasonable chara I there under, 410 IAC	diena, and in support of acter, are able to comply 26 and will operate and
tify that the operational policies of the clini	C Will and movide for discrimination based		
ear and allism under the penalty of penury plete and that I will comply with all regulati	that allustate as and a second as a second		
ature of the Medical Director:	JAHA #)	
ed Name and Tille;	14	dical Dire	ctor
of Signature (min/ad/yyy):	0/13/2017		
ature of the Clinic inistrator:	Issier Strewla	Que)	
ed Name and Title:	ssica Stienbarg	1	1 Center me
of Signature (mm/dd/yyyy):	113/17	,	
e the following page for in	structions regarding the	ancure food or	and mark walls at
his application.	747 4011 4 1101	PLICA DECA ME	

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
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V	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00
Jiana II	710	Φ0,1

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

- 1. A completed Application for License to Operate an Abortion Clinic (this form).
- 2. Any supporting attachments.
- 3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's admitting privileges; or
 - (B) A copy of:
 - (1) his/her written agreement with another physician with admitting privileges; and
 - (2) a copy (in writing) of that physician's admitting privileges.
- 4. Payment made payable to "Indiana State Department of Health."

Mail to:





		<u>Division</u>	of Ac	cute Care Use Only		
Date Received (mm/dd/yyyy)	Date Appro	ved (m	nm/dd/yyyy)	Date Rejecte	d (mm/dd/yyyy)
Please Type or P	rint Legibly.					
A 40		SECTION	I - TYP	PE OF APPLICATION		
Application (Chec	Ck appropriate	☐ Change of Ownershi	ip (Anticed copy	cipated date of Sale/Pure of the bill of sale, lease or	chase/Lease (mm/d other document of	d/yyyyi) transfer.
		SECTION II -	IDENT	IFYING INFORMATIO	N	
A. Abortion Clinic						
Women's Me	d Group P	rofessional Corpor	ation			
Street Address (number 1201 N Arling	ton Ave					P.O. Box
City Indianapolis Telephone Number				County Marion		ZIP Code +4 46219
relephone Number	Fax Number					
(317) 353 9371	(317) 322-335	Abortion Clinic e-mai	il addres	s: <u>martyh@forter</u>	ngt.com	
		Internet Web Address	s:W\	ww.womensmed.	com	
R Mailing Addma	GE different E					
Street Address (number	er and street	om abortion clinic location	1)			
City						P.O. Box 43100
Cincinnati, OF	1			County		ZIP Code +4
				Hamilton (OF	H)	45243
C. Licensee/Owner	ship Informa	tion				
vvomen's ivie	d Group Pi	tered with the secretary of sta rofessional Corpor	ate ation			
Street Address (number	er and street)					P.O. Box 43100
Cincinnati				State		ZIP Code+4
Cincinnati				ОН		45243-0100
elephone Number 513)272 0002		Number	EIN N	umber -1148155	Fisc	al Year End Dale (mm/dd)
10/2/2 0002	1(5)	3)272 0052	51	-1140133		12/31

D. Services provided under this license:		
1	employee(s), 2. Provided by a contract service, 3. Both 1 at	nd 2.
1. Ancillary Services: 3 Laboratory: C	LIA Certificate Number 15D353797	1 Radiology Counseling
1 Family Planni	ing 1 Pharmacy Other (List):	
i e	Other (List):	
For item 3, indicate the total number of individuals (empl	oyees plus contractors) working in this clinic. This includes h	ourly, part-time, and full-time persons.
3. Staffing: Physicians: 2 Registered N		
Licensed Social Works	Other (List title and number);	
E. Number of Procedure Rooms Utilizin	g:	
Local analgesia/anesthetic 2	Moderate/Conscious Sedation	0
F. Type of Entity:		
<u>For Profit</u>	Non-Profit	Government
☐ Individual	☐ Church Related	
Partnership	☐ Individual	☐ State ☐ County
☑ Corporation	Partnership	☐ City
Limited Liability Company	Corporation	☐ City/County
Sole Proprietorship	Limited Liability Company	☐ Hospital District
Other (specify)	Other (specify)	☐ Federal
		Other (specify)
		1

G. Officers (if the business entited Position		Name	A.J.1	-10:1-101 : 5:5	
			PO Box 431	s/City/State/ZIP	
President/Chairperson/CEC	W Ma	artin Haskell, MD		Cincinnati, OH 45243	
Vice-President/Vice-Chairperson/COO			Cincinnati, C	JH 45243	
Treasurer/CFO	Vale	rie Haskell	10 mm	PO Box 43100	
				Cincinnati, OH 45243	
Secretary	Vale	erie Haskell		PO Box 43100	
			Cincinnati, O	H 45243	
H. Ownership and/or Change in O	vnershin.				
List names and addresses of individu	als or omanizati	ons having direct or indirect our	perchip or controlling into		
in the applicant entity. Indirect owner entity higher in a pyramid than the ap					
Name		Business Address/6		EIN Number	
N Martin Haskell, MD		PO Box 43100, Cincir	nati, OH 45243		
	CER	TIFICATION OF APPLICATION	V		
The undersigned hereby makes application, represents and shows with the Abortion Clinic statues, IC 16 naintain this clinic in accordance with certify that the operational policies of swear and affirm under the penalty of complete and that I will comply with all	-21-2-2.5 and IC those rules.	16-34, and the rules promulgat	ed there under, 410 IAC	acter, are able to comp 26 and will operate and d, or national origin.	
omplete and that I will comply with al	regulations, law	s, and rules governing the licen	sing of clinics in Indiana.	- moreto are correct ar	
	11	Maple (h)			
rinted Name and Title:	Martin Has	skell, MD			
ate of Signature (mm/dd/yyyy):	6 June 20	17,			
ignature of the Clinic dministrator:	1111	Jara 11110			
rinted Name and Title:	Martin Ha	skell, MD			
ate of Signature (mm/dd/yyyy):	6 June 20				